

Michigan Call to Action to Reduce and Prevent Infant Mortality

Infant Mortality Summit: Work Group Recommendations

In October 2011, the Michigan Department of Community Health (MDCH) convened stakeholders from across the state to create Michigan's Call to Action to Reduce and Prevent Infant Mortality. The MDCH hosted a summit¹ to share information on infant mortality prevalence, disparities, and contributing factors; to highlight best practices, including those under way at the state and local community levels in Michigan. Michigan has a strong foundation of strategies aimed at improving the health of mothers and their infants, including programs that provide prenatal care, outreach and home-visiting services, nutritional services, and support for breastfeeding. Summit participants were asked to identify ways to "move the needle" and help Michigan make further progress in reducing infant mortality.

Nearly 300 summit participants were split into 15 work groups. Each work group was assigned a topic for discussion based on the contributing factors for infant mortality: individual and family circumstances; social issues; health care; and medical conditions. The work groups were asked to suggest three to five top priority strategies to reduce and prevent infant mortality in Michigan, with a focus on reducing disparity. Summit participants were also asked to identify the priority strategies they will personally support and the specific additional steps they will take to help reduce and prevent infant mortality on a *Take Action!* commitment form.

Public Sector Consultants compiled and reviewed work group recommendations to identify common themes. Several underlying principles resounded across work groups as they presented their suggestions and rationale for various strategies. These underlying principles should be considered as policies, programs, and strategies are developed, implemented, or expanded:

- Awareness of and attention to the influence of social determinants
- Promotion of the health of women throughout their life
- Use of clear and consistent messaging
- Dedication of resources to support evidence-based policies and programs

In addition to the underlying principles that emerged from work group discussions, work groups suggested the following targeted strategies to reduce and prevent infant mortality:

- Improve preconception health and reduce unintended pregnancies.
- Expand home-visiting programs.
- Promote safe sleep practices.
- Restore the regionalization of perinatal services.
- Promote statewide adoption of policies to eliminate medically unnecessary deliveries before 39 weeks gestation.
- Encourage statewide adoption of progesterone treatment for women identified as high-risk for preterm delivery.

Recommendations are described below, along with some of the specific ideas work groups suggested for implementation.

¹ The summit was sponsored by the W.K. Kellogg Foundation, the Early Childhood Investment Corporation, and the Michigan Department of Community Health, Women, Infants & Children Division.

RECOMMENDATIONS

Awareness of and attention to the influence of social determinants

Several work groups voiced agreement with the summit presenters that policy decisions must be viewed through a “health equity lens.” Gender oppression, institutional racism, and economic disparity are recognized as the root causes of infant mortality. Work groups offered the following suggestions to raise awareness of these social determinants and reduce inequities.

- **Implement Practices to Reduce Infant Mortality through Equity (PRIME):** PRIME (an MDCH project funded by the W.K. Kellogg Foundation) seeks to promote an understanding of practices that support institutional racism. Effective implementation of PRIME may help eliminate disparities in other health outcomes as well. Develop a core curriculum, toolkits, and workshops on racism to foster the development of individual and corporate strategies to educate the public as well as health and human services staff on the social determinants of infant mortality. Use resources such as the Undoing Racism® Workshop from The People’s Institute for Survival and Beyond.
- **Initiate a dialogue with stakeholders on social determinants:** Inform and educate stakeholders about how gender oppression, institutional racism, and economic disparity contribute to infant mortality. Make these issues an intentional part of the dialogue.
- **Educate the public and local media:** Hold town hall meetings to provide information on social determinants of health and the importance of addressing these issues.
- **Educate health care providers:** Offer continuing education for physicians and nurses to increase understanding about how gender oppression, institutional racism, and economic disparity influence disparities in infant mortality.
- **Advance societal perspectives of women:** Use social media, social marketing, and advertising campaigns to advance the image of women and promote positive cultural change regarding the value of girls and women. Support and expand programs such as Girls on the Run which develop girls’ self-respect and promote healthy lifestyles.
- **Emphasize “place matters”:** Consider the impact on infant mortality of policies that influence where women live, work, and play. Work with the Department of Environmental Quality to limit environmental exposures. Modify zoning ordinances to promote healthy environments with access to healthy foods and opportunities for physical activity.
- **Diversify the health care workforce:** Offer incentives to encourage more racially and ethnically diverse people to enter the health care professions.

Promotion of the health of women throughout their life

Several work groups also echoed the presenters when they emphasized the importance of women’s health throughout their life course (before and between pregnancies; during pregnancy; during infancy; and during childhood and adolescence). The environment in which women live during each phase influences their own and their child’s development and well-being. The following suggestions were made to encourage use of the life course perspective:

- **Adopt an institutional/organizational focus on the life course:** The Michigan Department of Community Health, local public health departments, and community-based organizations should all use the life course model in program planning.
- **Engage youth as problem-solvers:** Involve youth in similar infant mortality summits or teen advisory boards to seek their input on barriers to reducing infant mortality and brainstorm solutions.

- **Target teenagers and women prior to conception:** Reach teenagers and women at risk before they become pregnant to reduce unintended pregnancies. Disseminate information about the importance of preconception health through providers who have frequent contact with women before conception, including dentists, chiropractors, pharmacists, physical therapists, and school health clinics.

Use of clear and consistent messaging

The need for clear and consistent messaging regarding infant mortality was raised by many of the work groups. Public health departments, health care providers, nonprofit organizations, businesses, news sources, and the broader community should coordinate their messages on infant mortality in order to create a strong, unified voice. Almost all work groups emphasized the importance of communication with youth, women, families, health care providers, legislators, and the community about infant mortality risks, prevention, and the impact of public policy decisions. Some specific suggestions about how to establish effective messaging are described below:

- **Partner with the media:** Utilize available technology, social media, and social marketing tools to spread messages on infant mortality. Provide media with public health messages regarding infant mortality and identify funding streams to support media campaigns.
- **Tailor messages:** Tailor messages to address target populations' beliefs, values, and concerns. Policy-makers, families, educators, and health care professionals each require specific framing of this issue. Convey all of the benefits associated with breastfeeding, safe sleep, prenatal care, and preconception health.
- **Create culturally and developmentally appropriate messages:** Empower community members to offer their own ideas on how to develop culturally sensitive and intergenerational messages using a community engagement model. Provide incentives for target populations to participate in focus groups.
- **Repeat messages:** The necessity of repeating any educational or motivational message multiple times has been well demonstrated.
- **Call on all stakeholders:** Empower a broad range of stakeholders and non-traditional partners (e.g., educators, policy-makers, city planners, faith-based communities) to relay messages on infant mortality. Promote awareness about contributing factors and how infant mortality affects everyone in order to create a shared responsibility and maximize use of limited resources. Train community health workers and providers at all points of contact to convey messages to their clients regarding prevention of infant mortality.
- **Empower teenaged girls and young women:** Provide general education on the importance of behavioral risk factors, preconception health, birth control, family planning (Plan First!), prenatal care, and home-visiting programs. Use social marketing and commercials to instill among young women a sense of confidence in their own potential and portray the consequences of unintended pregnancies.
- **Engage fathers:** Health care providers should encourage fathers to be involved and educate them on the importance of their support early on and throughout pregnancy. Consider the development of infant mortality prevention programs and activities focused on dads. Identify barriers to fathers' involvement and tailor messages to break down those barriers (e.g., fear of paying child support).

Dedication of resources to support evidence-based policies and programs

Several work groups stressed the importance of investing or, in the case of some programs, reinvesting funding to ensure statewide implementation and sustainability of programs that have

demonstrated success in reducing the risk factors associated with infant mortality and achieving positive pregnancy outcomes.

- **Garner political will:** Cultivate a sense of urgency for sufficient and consistent state funding by educating legislators and their constituents on the impact of infant mortality. Engage communities to advocate for funding and distribute information on the efficacy of evidence-based programs and the return on investment.
- **Dedicate resources for prevention of infant mortality:** Develop trust funds designated for prevention of infant mortality and supported with money from the state, foundations, and business community.
- **Reinstate funding for prevention of unintended pregnancy:** Increase funding for unintended pregnancy prevention programs, family planning programs, and comprehensive health education in schools.

Improve preconception health and reduce unintended pregnancies

Several work groups suggested improving access to health care, service delivery, and education throughout the life course to improve preconception and interconception health and reduce unintended pregnancies. Support of Plan First! and Well Women programs was mentioned specifically.

Access to health care

- **Provide comprehensive health care coverage:** Ensure that women have access to regular primary care, HPV vaccination, family planning, contraception, pre-conceptual counseling, prenatal care, midwifery care, and mental health care.
- **Increase provider reimbursement:** Increase Medicaid reimbursement for providers to increase the number of providers that accept Medicaid patients. In particular, increase Medicaid reimbursement for the Maternal Infant Health Program.
- **Standardize reimbursements across providers:** Create a state-level task force to identify creative financing strategies and federal matching funds to address reimbursement inequities between providers in different settings. For example, Federally Qualified Health Centers, rural health clinics, and private providers are all paid at different rates, which could be standardized. Adequate reimbursement will improve access to obstetric care.
- **Increase provider accessibility:** Encourage providers to increase outreach. Support training in cultural competency and sensitivity. Work to eliminate transportation barriers and increase the number of hours that providers are available.

Service Delivery

- **Promote comprehensive, coordinated care:** Use a care model that encompasses physical and mental health and takes into consideration the social issues or challenges women face.
- **Integrate service delivery:** In rural areas especially, increase the number of maternal and child health services provided in one encounter. Multi-purpose delivery points can eliminate the need for families to make multiple trips to multiple providers for different services.
- **Promote family-centered care:** Policies and programs should be tailored to families' needs. Train providers on the family-centered model. Involve families at all levels of decision making to promote empowerment and ownership of their situation.
- **Use population management systems:** Develop a systems approach to identify women and target messaging toward them. Integrated health records and information systems such as Electronic Health Records can help identify women at risk for adverse pregnancy outcomes

(due to diabetes, hypertension, or other chronic illness). Take advantage of the fact that hospitals and health systems are required to conduct community health needs assessments and use these to identify community health needs and determine target populations.

- **Promote equitable access to the medical home:** Use centering pregnancy models and multi-disciplinary teams to facilitate partnerships between women and their primary care provider. Pilot a program among obstetrics/gynecology providers similar to the Children's Healthcare Access Program (CHAP) in Kent County. Use a cost-benefit analysis to evaluate its effectiveness.
- **Expand school health services:** Make physical and behavioral health services available to youth through school-based health centers and nurses. Counseling, access to contraceptives, family planning, and sexually transmitted disease (STD) education and treatment are examples of services that need to be available in schools.

Education

- **Expand the Michigan Model:** The Michigan Model should be expanded across the state and its curriculum for K–12 education should be enhanced to include discussions on health disparities, family violence, sexuality, pregnancy prevention (both contraception and abstinence), self-esteem, and nutrition. Parenting and life skills education—including child development, nutrition, home management, and safe sleep practices—should be required in high school for both males and females. Partner with the Michigan Department of Education to develop these curricula.
- **Encourage conversations between parents and children:** Promote the Talk Early & Talk Often program to encourage conversations between parents and their children. Encourage parents to use the resources available from this initiative to assist them in educating their middle-school-aged children on topics related to sexuality.
- **Urge health professionals to promote parent-adolescent communication:** Encourage health professionals, including obstetrics/gynecology providers, to support communication by encouraging patients to talk with their children about issues of sexuality and the consequences of early pregnancy. Develop a checklist for medical professionals to assist them in this role.

Expand home-visiting programs

Several groups suggested strategies that offer women and their families social and medical supports throughout preconception, pregnancy, and motherhood. Emphasis was placed on programs and approaches with proven results and a solid evidence base.

- **Build on home-visiting programs that exist in Michigan:** Leverage state and federal dollars to support programs such as the Maternal Infant Health Program and Nurse-Family Partnership (NFP) and increase their capacity. Use a targeted expansion of the NFP that focuses on first-time moms, and produces long-term results and positive pregnancy outcomes.
- **Expand Early Head Start programs:** Early Head Start programs should be supported and expanded across the state.
- **Expand community outreach programs:** Support and expand community outreach and peer-to-peer mentoring programs that recruit mentors from the community to provide outreach and support to women and their families.
- **Encourage the use of social media:** Home-visiting programs should utilize social media as a communication tool with their clients (e.g., Text4Baby) and use a centralized entry system.

- **Mobilize and support community-based networks and organizations:** Take advantage of wrap-around programs that are connecting health and human services. Develop a community-wide clearinghouse of resources to provide access to services and educational materials, including information on what works and what doesn't.
- **Allow “flexible consistency”:** Consistency of program services across the state is important, but so is maintaining the ability to tailor programs and tools. Allow communities to adapt programs to maximize their resources and meet their needs while adhering to evidence-based practice.

Promote safe sleep practices

Safe sleep practices were discussed among work groups from all focus areas. Suggested strategies include actions on the part of individuals, businesses, hospitals, health care professionals, media, and the community at large.

- **Increase messages and conversations on safe sleep:** Hospitals should make posters and videos available in hospital rooms to share with families prior to discharge. Health professionals across the continuum of care should engage new mothers in conversations about where their baby sleeps/naps. A safe-sleep toolkit could be modified for use in baby-sitting courses offered at hospitals, YMCAs, etc.
- **Increase social marketing:** Partner with retail outlets (e.g., Meijer) and business partners with the same target audience to spread the message on the importance of safe sleep practices. Use emotionally charged public service announcements or advertisements with stories from women that have experienced the death of an infant.
- **Emphasize “safe sleep practices”:** “Back to sleep” is only one element of “safe sleep practices.” Educate the community, families, and providers about safe sleep practices.
- **Provide new mothers with safe places for their babies to sleep:** Provide Pack and Plays and Sleep Sacks to all families when newborns are discharged from hospitals. Require families to complete an education module consisting of a video or brief class in order to qualify for these items. Seek creative financing and distribution methods.
- **Reduce the use of unsafe sleep products:** Educate health professionals and the broader community with messaging about the risks of bumper-pads and other unsafe sleep products. Engage in a dialogue with businesses responsible for producing and promoting products that contribute to accidental infant deaths. Ensure that existing and future products are safe and that proper use is heavily marketed. Pass a statewide ban on sale of bumper-pads and other unsafe sleep products.

Restore the regionalization of perinatal services

Work group participants acknowledged that significant work has already been done in Michigan to develop recommendations for perinatal regionalization. Work groups focusing on health care and medical conditions said that implementation of the recommendations from the 2009 task force on perinatal regionalization would improve infant health outcomes and safety. They identified a critical need for more human and financial resources to achieve successful restoration of a regional perinatal system in Michigan so that pregnant women and infants receive the right care, at the right time, at the right place.

Eliminate medically unnecessary deliveries before 39 weeks

Each medical conditions work group offered recommendations to reduce medically unnecessary deliveries before 39 weeks, as did several health care work groups. It was noted that change in

this regard will require a shift in cultural norms and expectations among both women and their care providers.

- **Reduce demand among women:** Beginning with the first prenatal care appointment, health care providers should educate women about the risks associated with medically unnecessary deliveries before 39 weeks. Pharmacists could be valuable partners in educating community members on the risks associated with pre-term births.
- **Implement hard-stop policies:** Educate providers, hospitals, and patients on the risks associated with elective deliveries. Hard-stop policies should be in place at all birth hospitals in the state. Toolkits on hard-stop policies can be supplied by the March of Dimes. Encourage hospitals and health systems to require the approval of the chief of obstetrics and gynecology for elective deliveries prior to 39 weeks. Promote adoption of a universal set of criteria for approval of deliveries before 39 weeks using the Michigan Health and Hospital Association (MHA) Keystone Center for Patient Safety & Quality, Trinity Health, and the American Congress of Obstetricians and Gynecologists (ACOG) as resources.
- **Garner support and organizational endorsements:** Seek support from the MHA, Leapfrog Group, and other major health organizations in the state to promote the adoption of hard-stop policies.
- **Prohibit payment:** Insurance plans and third-party payers should align payment with best practice by eliminating payment for medically unnecessary deliveries before 39 weeks.

Encourage statewide adoption of progesterone treatment for women identified as high-risk for preterm delivery

Almost all medical and health care work groups echoed Dr. Parisi's recommendation to encourage progesterone treatment for women identified as having a short cervix.

- **Standardize mid-trimester cervical-length screening of pregnant women using ultrasounds:** Make cervical screening part of an existing checklist for providers. For those women identified as having a short-cervix, encourage prescription of progesterone gel. Encourage commitment statements from all physicians to make the measure of the cervix in the second trimester a standard of care.
- **Provide payment for screening and treatment:** Add screening for cervix measurement to insurance plans' benefits packages. If indicated, progesterone treatment should be covered without prior authorization barriers, especially for women on Medicaid. Use a cost-benefit analysis to demonstrate the financial benefit of using screening to prevent pre-term births.
- **Educate the public and health care professionals:** Identify physician champions on this issue to encourage and educate their colleagues on the benefits of cervical-length screening and progesterone use for prevention of preterm births. Use mechanisms such as physician grand rounds, continuing education opportunities, and public health messaging to create urgency for implementation.

As the clinical strategies described above are implemented, one work group suggested that guidelines be developed for elective inductions, C-sections, cervical-length screening, second trimester ultrasound, progesterone prescription, and safe sleep practices. They should all have clear standards and Michigan Quality Improvement Consortium (MQIC) guidelines. Health plan medical directors should promote development of these guidelines and endorsement should be sought from the Michigan State Medical Society and Michigan Osteopathic Association, among others.

Ongoing evaluation was also prescribed for all of the clinical strategies above. For example, each year the Vital Statistics department should publish how many children are born at 35, 36, 37, and 38 weeks to determine the efficacy of hard-stop policies.

NEXT STEPS

Work group recommendations will be considered by the Michigan Department of Community Health as it works to develop a draft Michigan Action Plan to Prevent and Reduce Infant Mortality. The MDCH Infant Mortality Steering Committee will review and help finalize the action plan.

Meanwhile, all summit participants were encouraged to consider the additional steps they or their organization can take to help prevent and reduce infant mortality in Michigan. There were 135 people who completed a *Take Action!* commitment form during the conference. Of these, 119 said they would spread the word by sharing information on the importance of reducing infant mortality with at least 10 contacts; 128 made specific commitments to support strategies recommended at the summit.